Force-feeding–a clinical or administrative decision?

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Hunger strikes among prisoners are relatively rare. But when they do occur, public attention is dramatically drawn to them. Such attention is, of course, one of the prime objectives of prisoners, who often wish to publicize their cause. Each case then — as seen in the suffragettes and more recently the IRA in Britain or the Doukhobors in Canada — serves to stoke the debate on the legality and morality of force-feeding which has continued through most of the history of prison medicine. As is the case in any moral controversy, the debate is heavily tinged with emotion.

There appear to be two basic issues. First there is the moral issue itself, which entails a battle between the obligation of benevolence and that of respect for human freedom. Which is higher in the hierarchy of values? Second, who acts as arbitrator? Is a decision to be made in each instance by the attending physician himself or should the prison authority, after receiving advice on the medical consequences, make the decision? What are the boundaries of clinical independence?

One of the most recent attempts to look at the moral issues surrounding force-feeding in Canada occurred at the conference on the legal and ethical aspects of health care in the Canadian Penitentiary Service in Kingston in November 1975. In an attempt to discover the philosophical bases for ethical reasoning in the conference, Professor B.F. Brown of St. Michael's College, Toronto, noted that in the case of force-feeding the basic conflict is between the principle of informed consent and that of benevolence. Is one individual's freedom of choice to be limited by another individual's moral obligations to benevolence? Or in this case, is freedom the highest human value? Those who value freedom of self-determination above all, even life itself, advocate noninterference. Others feel that when the choice is suicidal, the human moral obligation to benevolence impels intervention — in a medical context, the physician must attempt to save life and preserve health.

Brown went on to consider the additional limitations imposed upon an individual's freedom of self-determination if one considers that a human's obligations to society extend beyond that of law. Legally one now has the liberty to take one's life (although this remains a crime in many jurisdictions) — however does one have the moral right? Does one's obligation to society include the preservation of one's own life? The prisoner does not lose all of his moral claims on society — conversely he does not lose his obligations to society either.

A further limitation is placed on the prisoner who, as a result of his being a ward of the state, cannot perform suicide in a private manner. The act necessarily obtrudes on the personal privacy of his attending physician and may challenge that physician's own moral values.

These issues engendered a lengthy debate at the conference on the morality of force-feeding. Although some participants strongly opposed force-feeding, the following recommendation was finally passed with a large majority.

> It is the duty of the health professional staff to be aware of the state of health of all inmates. The health professional staff [member] shall take all professionally acceptable measures to maintain good physical and mental health, except that he shall not intervene without the consent of the inmate-patient *unless the situation is an emergency and his life is threatened.*

The Committee on Ethics of the CMA met to consider the guidelines as prepared by the conference. Their reaction was indicative of the moral controversy that still surrounds the issue of force-feeding. The committee was in general agreement with the proposals *except* the one about force-feeding. Since no consensus could be reached on that issue, it was referred to the Board of Directors. The board itself proferred no opinion on the issue, stating that, insofar as the guidelines were not officially sent from the CPS, it was not the board's prerogative to amend, edit or comment on the issue.

The CMA does however have a policy on the issue. In October 1975 the 29th World Medical Assembly issued the Declaration of Tokyo. Declaration 5 reads:

> Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, *he or she shall not be fed artificially.* The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

Subsequently the CMA issued a statement on the Declaration of Tokyo that contained the following:

> The doctor must have complete clinical independence in deciding upon the care of a person for whom he/she is medically responsible. *The care of a prisoner or detainee who refuses nourishment shall include artificial feeding.*

Who decides?

Whose responsibility is it to decide on the morality of force-feeding? Should the prison rules interpose in a physician/patient relationship by ruling on the subject or is that relationship sacrosanct? In Canada it is the policy of the Canadian Penitentiary Service to preserve the life of prisoners — including force-feeding when necessary. The onus of responsibility is hence lifted off the shoulders of individual physicians and placed on the penitentiary service itself. Although a diminishment of clinical independence is involved, a look at the situation in Britain points out the benefits of having a national policy on the issue.

Britain has opted for clinical independence. It is the attending physician that in each instance makes the decision. A recent review of the medico-legal implications surrounding force-feeding (*BMJ* 2: 823, 1976) points out the confusion engendered by Britain's policy.

The British Medical Association has supported the policy of clinical independence. In 1974, under pressure from the IRA hunger strikes, the BMA central ethical committee issued a statement that when force-feeding had to be considered the prison medical officer must be given complete clinical independence.

Shortly after the BMA central ethical committee released its statement, Roy Jenkins, then home secretary, brought up the issue of force-feeding in the Commons. In conjunction with the BMA's main thrust, he stated that force-feeding was not a requirement by law but rather a medical judgement to be made by the responsible physician. However, he went on to state his *personal* view of the matter. The physician's first responsibility is to ensure that the prisoner is of sound mind. This opinion must be confirmed by an outside consultant. The prisoner must be then duly informed that force-feeding is not a requirement of prison medicine and warned that the deterioration of his health might be allowed to continue unless he specifically requests medical

intervention. The prisoner would then continue to receive normal medical supervision and food would be made available to, but not forced upon, the prisoner.

To many, this statement was interpreted as an end to force-feeding in Britain. Yet force-feeding in that country, although declining, continues. Mr. Jenkins' statement in the Commons remains but suggestive; the prison rules place the responsibility for the prisoner's health solely in the physician's hands. The decision is made according to the personal views of the prison medical officer in charge.

The situation in Britain has led to the suggestion that the physician is not the proper arbitrator as to the morality of force-feeding. An amendment to the prison rules would not only protect physicians from charges of inconsistency in their treatment of hunger strikers but also would insure them against the vagaries of common law.

According to the above-cited article, the only existent authority resides in a directive by the Lord Chief Justice in 1909 to a jury trying an assault action brought by a suffragette who was force-fed. The directive states it is the duty of prison officials to preserve the health and lives of those in the custody of the crown. If then, as the directive implies, force-feeding is lawful, failure to do so could, in the extreme instance, be interpreted as manslaughter by omission. It is, of course, unlikely that the decision not to force-feed would — in light of today's medical opinion — be equated with "gross negligence".

Alternatively, it has been argued that the decision to force-feed could — at least in Britain — be interpreted (under section 47 of the Offenses against the Persons Act 1861) as assault occasioning actual bodily harm. The physician then, at least hypothetically, is placed in that untenable position: damned if you do — damned if you don't. This dilemma was uniquely bypassed in what has delightfully been termed the "Cat and Mouse Act" passed in Britain expressly to handle the hunger strikes of the suffragettes. Under this act hunger strikers were released from prison and then re-detained once they were fit again.

In Canada, failing specific legislation (and this is almost an impossibility, given that the situation is made-to-order for federal-provincial buck-passing) Canadian courts would presumably apply the common law that is largely inherited from England. But the courts would undoubtedly, in considering what is assault and what is acceptable medical practice, look at directions issued under the prison rules and any statements issued by an authoritative medical body, such as the CMA or a provincial college.■

CORONERS

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sies for metropolitan Toronto are performed here.

Sometimes, says Chief Coroner Cotnam, parts of bodies are sent to the coroner's building for analysis, and work in identification makes use of sophisticated techniques in such fields as forensic odontology.

Dr. Cotnam explains that all local coroners' reports come to the Grenville Street building. He speaks of the sweeping changes that have occurred in, for instance, the Construction Safety Act as a result of investigations followed by recommendations, as well as in the Child Welfare Act and other legislation relating to battered children.

According to the Ontario Coroner's Act, Cotnam's job is to "administer this act and its regulations; supervise, direct and control all coroners in Ontario in the performance of their duties; conduct programs for the instruction of coroners in their duties; bring the findings and recommendations of coroners' juries to the attention of appropriate persons, agencies and ministries of government; prepare, publish and distribute a code of ethics for the guidance of coroners; (and) perform such other duties as are assigned to him by or under this or any other act or by the regulations or by the Lieutenant-Governor-in-Council."

And there are, says Dr. Cotnam, many other acts that impinge on his work, among them those concerning vital statistics, cemeteries and mining.

Cotnam believes strongly that attempts to bring some national uniformity to the coroner's system are long overdue; in fact, he was the first president of an organization designed to do that. "We need to get the statistical information out on a national basis," he says.

Perhaps more important, at least a priority within the movement toward national conformity, Cotnam believes, is the need to ensure that coroners' work is handled by physicians.

It may very well be that the coroner's lot, like the policeman's, is not a happy one. But it's one whose importance and effect are growing measurably.

The coroner, if he is to act as what Dr. Ross Bennett calls "an ombudsman for the dead", must enjoy the full support and cooperation and understanding of medical practitioners throughout Canada in order to protect the living, too, by encouraging high standards of medical and general safety.■